Title
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Publication Date
2020-03-01

DOI
10.1016/j.urology.2019.11.024

Peer reviewed

Urethral Defect in Setting of Recurrent Urethral Foreign Body Insertion

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We present a case of recurrent episodes of foreign body insertion into the urethra, ultimately resulting in urethral defect at the penoscrotal junction. We have decided against treating the urethral defect as it facilitates nonoperative retrieval of the urethral foreign bodies. We present our experience and rationale for the clinical management of this complex patient. UROLOGY 00: e1–e2, 2019. © 2019 Elsevier Inc.

A 50-year-old male has presented to our institution with >40 encounters for urethral foreign body insertion in setting of intoxication and/or psychosis (Fig. 1A). The patient consistently fails to follow-up for outpatient psychiatric treatment. More than 90% of foreign bodies have been removed cystoscopically

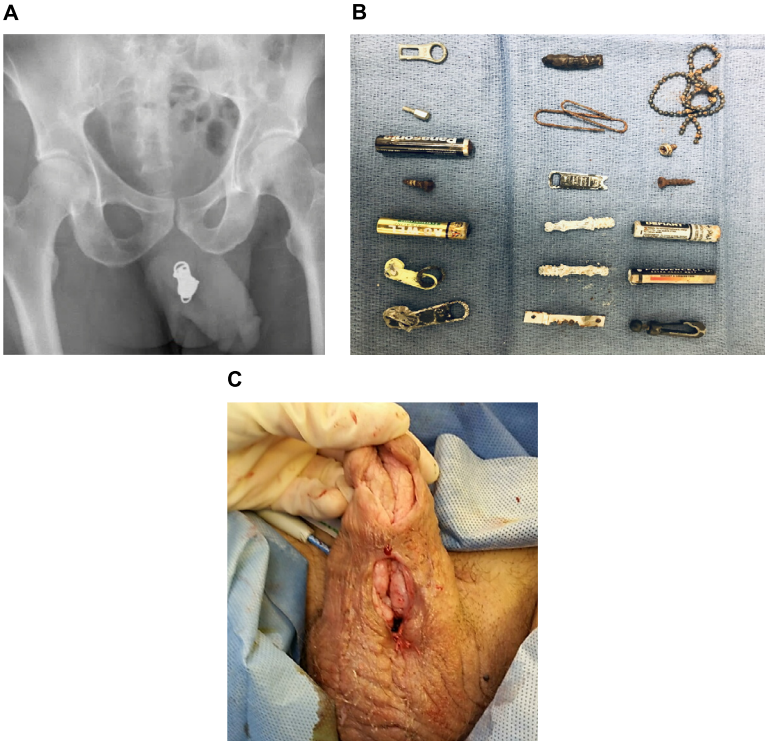

Figure 1. (**A**) Pelvic XR revealing multiple radiopaque objects in urethra. XR often obtained at presentation to characterize item(s) and location for retrieval. (**B**) A selection of objects extracted from patient. The objects most commonly inserted were safety pins (n = 7), paper clips (n = 4), batteries (n = 4), and screws (n = 4). Other objects included key chain (n = 1), shell casing (n = 1) candle (n = 2), rings (n = 2), hair clips (n = 2), porcelain tile (n = 1), spoon handle (n = 1), and metal hook (n = 1). (**C**) Urethral defect noted at the penoscrotal junction at the site of previous urethrotomy and acquired hypospadias.

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Submitted: July 12, 2019, accepted (with revisions): November 19, 2019

https://doi.org/10.1016/j.urology.2019.11.024
0090-4295

(Fig. 1B). Urethrotomies were required in 2009 (perineal) and 2016 (penoscrotal junction) after failure of endoscopic management.

In 2017, the patient presented with flayed open appearance of the penile urethra and a separate opening at the penoscrotal junction (Fig. 1C). The location suggests it was related to prior urethrotomy. We subsequently made the decision to defer reconstruction due to the patient's continued insertion behaviors. We feel the defect has made minimally invasive retrieval of foreign bodies more technically feasible due to its large caliber.

Urethral foreign body extraction should focus on minimizing urethral trauma. In this case, leaving the urethral defect untreated has helped achieve this goal. In our experience, most objects are amenable to endoscopic retrieval, and thus are considered first-line treatment. Endoscopic management should always be attempted prior to open surgical management.[1-5] We speculate that open surgery may increase risk of penile erosion, urethral fistulas, and urethral stricture disease.

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